DISABILITY/RETIREMENT CLAIM FORM

KCDRB Form 1

LEOFF-I Member's Application for LEOFF-1 Disability/Retirement Benefits

(To be completed by LEOFF-1 employee/applicant)

Please submit this form directly to your LEOFF-1 employer. If you have questions, call the King County Disability Retirement Board at 206-263-6394, or 206-684-1556 (call center).

I submit this application for LEOFF-1 disability/retirement leave benefits according to the provisions of RCW 41.26, WAC 415.150, and King County LEOFF-I Disability Retirement Board rules and policies.

I. Name: _____ Date of Birth: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

II. Specific position/rank/unit currently assigned: _____

Specific rank: _____

Unit currently assigned: _____

Employer/District: _____ Telephone: _____

Address: _____

III. First day of disability leave commenced on this date (MM/DD/YY): _____

Upon regular review by the board during this leave period, if the written medical evidence I submit from my physician(s) supports continuous disability, such that I am unable to perform the regular duties of my position with average efficiency, and indicate that disability leave must extend throughout a continuous six-month period, my last day of active-service status will be (six-months from the first day disability leave commenced) (MM/DD/YY): _____

IV. I returned to duty on this date (MM/DD/YY): _____

V. Use of sick or vacation leave benefits.

- ☐ My employer/department ***does not*** provide sick leave benefits.
- ☐ My employer/department ***does*** provide sick leave benefits.
- ☐ I ***did not*** use any sick leave or vacation leave benefits before applying for LEOFF-1 benefits.
- ☐ I ***did use*** sick or vacation leave benefits before applying for LEOFF-1 benefits on these dates:

_____

VI. Describe fully the date, place, cause and nature of the disability. Attach any supportive information, such as accident reports and medical exam reports taken at the time of the accident/injury/illness:

_____

_____

_____

_____

KCDRB Form 1 (continued)

VII. Burden of proof.

I have read and understand that under WAC 415-105-040(2), "the burden of proving the existence of a disabling condition, and whether or not the condition was incurred in the line of duty, shall be upon the applicant." Further, I understand if the medical evidence supports continuous disability and finds me eligible for disability/retirement consideration, the King County LEOFF-1 Board holds final jurisdiction of the line-of-duty finding, which cannot be appealed to the WA State Retirement Systems Director.

☐ My disability was not incurred in the line of duty.

☐ I believe my disability was incurred in the line of duty and submit the following information for the board's retirement consideration (member's explanation and dates of accident with copies of medical reports attached).

VIII. Did the disability incur while you were engaged in other employment?

☐ My disability ***was not*** incurred while engaged in other employment.

☐ My disability ***did*** incur while engaged in other employment. I have attached my explanation or employer's report.

IX. Medical information.

A signed affidavit (KCDRB Form 3) and/or a signed medical report letter from my physician(s) is attached with this claim. In addition, I've attached a list of all medical providers/physicians I have consulted within the last six-months related to this LEOFF-1 benefits claim. I give consent to be examined by any board-selected physician(s) required to determine my eligibility for LEOFF-1 disability/retirement benefits.

Release of medical report/information. For the purposes of verifying my eligibility for benefits under the LEOFF-1 statutes, I hereby authorize the release of records (copies, not originals) contained in my LEOFF-1 disability/retirement application file to requesting parties, such as my LEOFF-1 employer human resources or fiscal department, health provider, board-referred physicians/consultants, or others.

I reserve the right to be notified of all parties requesting such. I understand that all information included in my disability/retirement claim file will be forwarded to the Washington State Office of Retirement Systems and made part of a permanent record there, and is subject to inspection under the Public Records Act.

XI. Member Certification.

I HEREBY CERTIFY that all the information herein is true and correct to the best of my knowledge and belief. I have attached a signed affidavit(s) by my treating physician(s) with respect to my disability and authorize them to supply the King County LEOFF-1 Disability Retirement Board with medical information requested.

Job Description. I have included a copy of my current position duties or job description provided by my LEOFF-1 employer human resources department or supervisory officer/chief.

Signed: _____ Date: _____
LEOFF-I member

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.